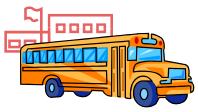

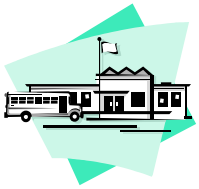

School-Based Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

August, 2004

This publication supersedes all previous School-Based Services handbooks. Published by the Montana Department of Public Health & Human Services, August 2003.

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My Medicaid Provider ID Number:

MONTANA
Department of Public Health & Human Services

Table of Contents

Prior Authorization (continued)

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone
(800) 639-8982 Fax
(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.state.mt.us	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information and a link to the Provider Information Website. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, DPHHS information, services available, and legal information.
Provider Information Website www.mtmedicaid.org or www.dphhs.state.mt.us/hpsd/medicaid/medicaid2	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
CHIP Website www.chip.state.mt.us	• Information on the Children's Health Insurance Plan (CHIP)
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides and other tools • EDI education

MONTANA
Department of Public Health & Human Services

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for the school-based services program.

Each chapter has a section titled *Other Programs* that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP). Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy. Notices and replacement pages are available on the Provider Information website (see *Key Contacts*).

Providers are responsible for knowing and following current laws and regulations.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rule references are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*). The following rules and regulations are specific to the school based services program:

- Administrative Rules of Montana (ARM)
  - ARM 37.86.2201 EPSDT Purpose, Eligibility and Scope
  - ARM 37.86.2206 - 2207 EPSDT Medical and Other Services; Reimbursement
  - ARM 37.86.2217 EPSDT Private Duty Nursing
  - ARM 37.86.2224-2233 EPSDT, CSCT and Health Related Services

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Contacts*).

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Program Overview

Title XIX of the Social Security Act provides for a program of medical assistance to certain individuals and families with low income. This program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the federal and state governments. Federal oversight for the Medicaid program lies with the Centers for Medicare and Medicaid Services (CMS) in the Department of Public Health and Human Services (DPHHS).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a special program for Medicaid beneficiaries under 21 years of age. The purpose of EPSDT is to ensure that through periodic check ups and early detection, children's health problems are prevented and/or ameliorated. The EPSDT program allows states to provide services even if these services are not covered under the Medicaid state plan for other beneficiaries.

The Medicare Catastrophic Coverage Act, enacted in 1988, contained provisions which permit state Medicaid programs to provide reimbursement for health-related services provided as part of a child's Individualized Education Plan (IEP). This reversed a previous policy that Medicaid could not reimburse for services provided by schools. As a result of this act, the State of Montana allows schools and cooperatives to bill for Medicaid services provided to Medicaid clients pursuant to an IEP.

Medicaid reimburses health-related services provided by schools that are written into an IEP, if the services are covered under the Medicaid state plan or are covered under EPSDT. Services billed to Medicaid must be provided by qualified practitioners with credentials meeting state and federal Medicaid program requirements. Medicaid provides reimbursement for health-related services and does not reimburse for services that are educational or instructional in nature.

Medicaid can be an important source of funding for schools, particularly because the cost of providing special education can greatly exceed the federal assistance provided under the Individuals with Disabilities Education Act (IDEA). Children who qualify for IDEA are frequently eligible for Medicaid services. Although Medicaid is traditionally the "payer of last resort" for health care services, it is required to reimburse for IDEA related medically necessary services for eligible children before IDEA funds are used.

In Montana, the Department of Public Health & Human Services, Medicaid Services Bureau, administers the Medicaid School-Based Services Program. This guide contains specific technical information about program requirements associated with seeking payment for covered services rendered in a school setting. The purpose of this guide is to inform schools on the appropriate methods for claiming reimbursement for the costs of health-related services provided.

Covered Services

General Coverage Principles

Medicaid covers health-related services provided to children in a school setting when all of the following are met:

- The child qualifies for Individuals with Disabilities Education Act (IDEA)
- The services are written into an Individual Education Plan (IEP)
- The services are not free. Providers may not bill Medicaid for any services that are generally offered to all clients without charge.

This chapter provides covered services information that applies specifically to school-based services. School-based services providers must meet the Medicaid provider qualifications established by the state and have a provider agreement with the state. These providers must also meet the requirements specified in the *School-Based Services* manual and the *General Information For Providers* manual. School-based services provided to Medicaid clients include the following:

- Therapy services (physical therapy, occupational therapy, speech language pathology)
- Audiology
- Private duty nursing
- School psychology and mental health services (including clinical social work and clinical professional counseling)
- Comprehensive School and Community Treatment (CSCT)
- Personal care (provided by paraprofessionals)
- Other diagnostic, preventative and rehabilitative services
- Specialized transportation

Services for children (ARM 37.86.2201 – 2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all school-based services described in this manual. All applicable PASSPORT To Health and prior authorization requirements apply (see the *PASSPORT and Prior Authorization* chapter in this manual.

Services within scope of practice (ARM 37.85.401)

Services provided under the school-based services program are covered only when they are within the scope of the provider's license.

Provider requirements

Most school-based services must be provided by licensed health care providers. The exception is that activities of daily living services may be provided by personal care paraprofessionals. Medicaid does not cover services provided by a teacher or teacher's aide; however, teachers or teacher aides may be used to assist in the development of child care planning. School-based services must be provided by only those providers listed in the table below.

Provider Type	Provider Requirements
Private duty nursing services provided by: • Licensed registered nurse • Licensed practical nurse	Nurses must have a valid certificate of registration issued by the Board of Nurse Examiners of the State of Montana or the Montana Board of Nursing Education and Nurse Registration.
Mental health services provided by: • Credentialed school psychologist • Licensed psychologist • Licensed clinical professional counselor • Licensed clinical social worker	Mental health providers must be licensed according to Montana's state requirements. School psychologist services are provided by a professional with a Class 6 specialist license with a school psychologist endorsement.
Therapy services provided by: • Licensed occupational therapist • Licensed physical therapist • Licensed speech language pathologists	These therapists are required to meet appropriate credentialing requirements as defined by the Montana Licensing Board.
Audiology	Must meet credentialing requirements as defined by the Montana Licensing Board
Personal care paraprofessional	No licensing requirements

It is the responsibility of the school district to assure appropriately licensed providers perform all Medicaid covered services. Each school district must maintain documentation of each rendering practitioner's license, certification, registration or credential to practice in Montana. Suspended Medicaid providers may not provide school-based services.

IEP requirements

Services provided to Medicaid clients must be covered by Medicaid and documented in the client's Individualized Education Plan (IEP). Medicaid does not cover health-related services that are not included in an IEP unless all of the following requirements are met:

- Youth is enrolled in Medicaid
- Services are medically necessary
- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

pre-licensed professional prior to program approval, but approval is not required for licensed providers.

- ***Children must have serious emotional disturbances.*** The CSCT program is intended specifically for children who have serious emotional disturbances, regardless of whether the child is eligible for special education services. This program is not intended for children with functional limitations who require support for activities of daily living (ADL). Children that require ADL support are covered by other Medicaid services like personal care paraprofessionals.
- ***Services must be medically necessary (ARM 37.82.102 and 37.85.410).*** CSCT services must be medically necessary. See *medically necessary* in the *Definitions* section of this manual. Medicaid considers experimental services or services which are generally regarded by the medical profession as unacceptable treatment not medically necessary.
- ***Documentation requirements (ARM 37.85.414).*** The clinical treatment plan for CSCT services paid by Medicaid must demonstrate how the services will address medical necessity. The service provider should maintain documentation that includes:
    - Date of service
    - Time in and time out
    - Who was served
    - Where service occurred
    - Result of service and how the service relates to the treatment plan and goals
    - Who provided the service

  This documentation, in addition to serving as documentation of services provided, also provides documentation for billing of CSCT services. In addition to this documentation and any clinical records required by mental health centers license rules, the CSCT program must maintain the following records:
    - Documentation of the child's attendance in school and in program services
    - Notes for each individual therapy session and other direct services
    - Weekly overall progress notes
- ***Services must be available to all qualifying children.*** CSCT services must be made available to all children that meet criteria for those services, not just because the child has Medicaid benefits. In the case of school-based programs that provide services to children

that do not have IEPs, Medicaid will pay for covered services if the following are in place:

- A fee schedule is established (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

The exception to this policy is the services that are provided to Medicaid eligible children and the services are written into the children's IEPs (see *IEP Requirements* in this chapter).

- ***Program must follow free care rule.*** Everyone who receives CSCT services must be billed for the services. If a service is free for non-Medicaid clients, then it is free for all children. Medicaid billable services provided under an IEP are not subject to the *free care rule* (see *IEP Requirements* in this chapter).

Services included

Strategies, coordination and quality improvement activities related to the individual child's treatment plans are included in the CSCT program in addition to the following direct care services:

- Individual, family and group therapy
- Social skills training
- Behavior intervention planning
- Crisis intervention services
- Case management
- School, family and community support

Service requirements

The CSCT program must be provided through a program of services staffed by at least two mental health workers who work exclusively in the school. At least one of the two mental health workers must be a licensed psychologist, licensed clinical social worker, licensed professional counselor, or a DPHHS approved pre-licensed professional. These workers must maintain caseloads not to exceed 12 severely emotionally disturbed (SED) youth.

- *Caseload* refers to the total number of clients enrolled in the CSCT program. It does not refer to a daily or average attendance. Ideally the staff and caseload should be all contained in one school. It is acceptable, however, for a CSCT program with a caseload of no more than 12 and a full-time staff of two to be spread across no more than two school campuses located in close proximity of one

- Exercising (ROM)
- Grooming
- Toileting
- Transferring
- Walking

Service requirements

- These services must be listed on the client's IEP.
- Approval must be given by the client's PASSPORT provider or primary care provider prior to billing for Medicaid covered services. For instructions on obtaining PASSPORT approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

Services restricted

Medicaid does not cover the following services provided by a personal care paraprofessional:

- Skilled care services that require professional medical personnel
- Instruction, tutoring or guidance in academics
- Behavioral management

Please see *Appendix B: Personal Care Paraprofessional Services Documentation*, which includes the child profile and service delivery record. The child profile provides detailed examples of activities of daily living.

Special needs transportation

Special needs transportation includes transportation services for clients with special needs that are outside of traditional transportation services provided for clients without disabilities.

Services include

Special needs transportation services are covered when all of the following criteria are met:

- Transportation is provided to and/or from a Medicaid-covered service on the day the service was provided
- The Medicaid-covered service is included in the client's IEP
- The client's IEP includes specialized transportation service as a medical need.

Specialized transportation services are covered if one of the following conditions exists:

- A client requires transportation in a vehicle adapted to service the needs of students with disabilities, including a specially adapted school bus

The school district must maintain documentation of each service provided, which may take the form of a trip log.

- A client resides in an area that does not have school bus transportation (such as those in close proximity to a school).
- The school incurs the expense of the service regardless of the type of transportation rendered

Services included
Special needs transportation includes the following:

- Transportation from the client's place of residence to school (where the client receives health-related services covered by the Montana School-based Services program, provided by school), and/or return to the residence.
- Transportation from the school to a medical provider's office who has a contract with the school to provide health-related services covered by the Montana School-based Services program, and return to school.

Medicaid does not cover special transportation services on a day that the client does not receive a Medicaid-covered service that is written into the IEP.

Services restricted
Clients with special education needs who ride the regular school bus to school with other non-disabled children in most cases will not have a medical need for transportation services and will not have transportation listed in their IEP. In this case, the bus ride should not be billed to the Montana School-based Services program. The fact that clients may receive a medical service on a given day does not necessarily mean that special transportation also would be reimbursed for that day.

Audiology

Audiology assessments are performed by individuals possessing the state of Montana credentials for performing audiology services.

Services included
Covered audiology services include the following:

- Assessment to determine client's medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.
- Services provided must be documented in the client's IEP.

Service requirements
Medicaid covers audiology services when the services to be provided during a school year are written into the child's IEP.

Services restricted
Medicaid does not cover the following audiology services:

- Testing for educational purposes
- Services provided during Child Find assessments

Authorization requirements summary

The following table is a summary of authorization requirements for school-based services that were described in each section above. For more information on how to obtain prior authorization and PASSPORT provider approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

Authorization Requirements

Service	Prior Authorization	PASSPORT Provider Approval	Written Physician Order/Referral
CSCT services	**No**	**No**	**No**
Therapy services	**No**	**Yes**	**No**
Private duty nursing services	**Yes**	**Yes**	**Yes**
School psychologist and mental health services	**No**	**No**	**No**
Personal care paraprofessional services	**No**	**Yes, if applicable** (If the client is enrolled in PASSPORT, PASSPORT provider approval is required.)	**Yes, if applicable** (If the client is not enrolled in PASSPORT, the client's primary care provider must provide a written order/referral.)
Specialized transportation services	**No**	**No**	**No**
Audiology	**No**	**No**	**No**

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The school-based services in this manual are not covered benefits of the Mental Health Services Plan (MHSP). However, the mental health services in this chapter are covered benefits for Medicaid clients. For more information on the MHSP program, see the *Mental Health* manual available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The school-based services in this manual are not covered benefits of the Children's Health Insurance Plan (CHIP). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647.

MONTANA
Department of Public Health & Human Services

PASSPORT and Prior Authorization

What Are PASSPORT, Team Care and Prior Authorization (ARM 37.86.5101 - 5120)

PASSPORT To Health, Team Care and prior authorization are three examples of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular client. PASSPORT approval and prior authorization are different, and some services may require both. A different code is issued for each type of approval and must be included on the claim (see the *Completing A Claim* chapter in this manual).

- ***PASSPORT To Health Managed Care Program*** is Montana Medicaid's Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. Most Montana Medicaid clients must participate in PASSPORT with only a few exceptions. The PASSPORT Program saves the Medicaid Program approximately $20 million each year. These savings allow improved benefits elsewhere in the Medicaid Program. For more information on PASSPORT To Health, see the *General Information For Providers* manual, *PASSPORT and Prior Authorization* chapter.
- ***Team Care*** is a utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. These clients must enroll in PASSPORT, select a PASSPORT primary care provider (PCP) and a single pharmacy, and call the Nurse First line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system. Team Care is a component of PASSPORT, and all PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program and Nurse First, see the *PASSPORT and Prior Authorization* chapter in the *General Information For Providers* manual or the *Team Care* page on the Provider Information website (see *Key Contacts*).
- ***Prior authorization*** refers to a list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. When prior authorization is granted, the provider is issued a PA number which must be on the claim. See *Prior Authorization* later in this chapter for instructions on how to obtain prior authorization for covered services.

Medicaid does not pay for services when prior authorization, PASSPORT, or restricted card requirements are not met.

In practice, providers will most often encounter clients who are enrolled in PASSPORT. Specific services may also require prior authorization regardless of whether the client is a PASSPORT enrollee. PASSPORT approval requirements are described below. In the few cases where an eligibility verification shows that a client is restricted to a certain provider or pharmacy, all providers must follow the restrictions on the eligibility documentation.

How to Identify Clients on PASSPORT

Client eligibility verification will indicate whether the client is enrolled in PASSPORT. The client's PASSPORT provider and phone number are also available on the eligibility verification, and the client may have full or basic coverage. Instructions for checking client eligibility are in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

How to Obtain PASSPORT Approval

When providing a covered medical service that requires PASSPORT approval, check the child's eligibility information for the client's primary care provider. Contact the primary care provider and request approval. It is important to communicate results of the health-related services provided by school-based medical providers to the child's primary care provider to promote coordination and continuity of care. The PASSPORT approval number must be recorded on the claim (see the *Completing a Claim* chapter in this manual).

How to Obtain Extended PASSPORT Approval

You may want to consider getting an extended approval from PASSPORT providers in your area. The school can write to all the client's primary care providers at the beginning of each year. Ask providers to sign an extended approval, good for that entire year, for health-related services that will be provided to the child during the school year as indicated in the child's IEP. This extended approval is only good for health-related services requested for each individual child. A provider is not obligated to and may choose not to approve requested services. In signing this extended approval, the PASSPORT provider gives his or her PASSPORT provider number to use when submitting claims. The PASSPORT approval number must be recorded on the claim (see the *Completing a Claim* chapter in this manual). PASSPORT numbers may change within a given year. If a wrong PASSPORT number is used, the claim will deny. Providers should check clients' eligibility verification monthly. If a new PASSPORT provider is shown, contact that provider for a new PASSPORT number.

When the provider accepts the client's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the client's local office of public assistance (see the *General Information For Providers* manual, *Appendix B: Local Offices of Public Assistance*). When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the services before billing Medicaid for the services.

Service Fees

The Office of Management and Budget (OMB A-87) federal regulation specifies one government entity may not bill another government entity more than their cost. Schools should bill Medicaid their cost of providing a service, not the fee published by Medicaid for the service. The Medicaid fee schedule is to inform provider of the maximum fee Medicaid pays for each procedure.

Coding Tips

Effective January 1, 2004, the procedure codes listed in the following table will be the only valid procedures for schools to use for billing Medicaid. Although schools may continue to utilize the procedure codes published in the July 2003 fee schedule until that time, it is recommended that providers use only the following procedure codes.

Any codes billed by schools on or after January 1, 2004 that are not listed in the following table, will be denied.

School-Based Services Codes

Service	CPT Code	Unit Measurement
Occupational Therapist		
Occupational therapy – individual therapeutic activities	97530	15 minute unit
Occupational therapy – group therapeutic procedures	97150	Per visit
Occupational therapy evaluation	97003	Per visit
Occupational therapy re-evaluation	97004	Per visit
Physical Therapist		
Physical therapy – individual therapeutic activities	97530	15 minute unit
Physical therapy – group therapeutic procedures	97150	Per visit
Physical therapy evaluation	97001	Per visit
Physical therapy re-evaluation	97002	Per visit
Speech Therapists		
Speech/hearing therapy – individual	92507	Per visit
Speech/hearing therapy – group	92508	Per visit
Speech/hearing evaluation	92506	Per visit
Private Duty Nursing		
Private duty nursing services provided in school	T1000	15 minute unit
School Psychologist/Mental Health Services		
Psychological therapy – individual	90804	Per 30 minute unit
Psychological therapy – group	90853	Per visit
Psychological evaluation and re-evaluation	96100	Per hour
CSCT Program		
CSCT services	H0036	15 minute unit
Personal Care Paraprofessionals		
Personal care services	T1019	15 minute unit
Special Needs Transportation		
Special needs transportation	T2003	Per one-way trip
Audiology		
Audiology evaluation	92557	Per visit
Tympanometry	92567	Per visit

Using modifiers

School-based services providers only use modifiers for coding when the service provided to a client is not typical. The modifiers are used in addition to the CPT codes. The following modifiers are typically used in schools:

- Modifier "52" is billed with the procedure code when a service is reduced from what the customary service normally entails. For example, a service was not completed in its entirety as a result of extenuating circumstances or the well being of the individual was threatened.

Comprehensive School and Community Treatment (CSCT)

If a provider spent 30 minutes in social skills training with a Medicaid client, it would be billed like this (the unit measurement for this code is 15 minutes):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
11	05	03	11	05	03	03	0	H0036		2	$ 40 00	2				

The CSCT program must follow the free care rule. That is, if it is free for non-Medicaid children, then it is free for all children.

The CSCT program must follow the *free care rule.*

Therapy services

Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the supervising licensed therapist's Medicaid provider number. Remember to include the client's PASSPORT provider's PASSPORT approval number on the claim (field 17a of the CMS-1500 form). See the *Completing a Claim* chapter in this manual. Thirty minutes of individual physical therapy would be billed like this (the unit measurement for this code is "15 minute unit"):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
12	02	03	12	02	03	03	0	97530		1	$ 40 00	2				

Private duty nursing services

Both PASSPORT and prior authorization are required for these services, so remember to include the PASSPORT provider's PASSPORT number and the prior authorization number on the claim (see the *Completing a Claim* chapter in this manual). Private duty nursing services provided for 15 minutes would be billed like this:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	02	03	09	02	03	03	0	T1000		1	$ 5 00	1				

School psychologists and mental health services

A psychological therapy session of 30 minutes would be billed like this (the unit measurement for this code is "per 30 minute unit"):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	02	03	09	02	03	03	0	90804		1	$ 50 00	1				

Personal care paraprofessional services

Remember to include the client's PASSPORT provider number on the claim (see the *Completing a Claim* chapter in this manual). Personal care services provided to a client for 2 hours during a day would be billed like this (the unit measurement for this code is per 15 minute unit):

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
09	02	03	09	02	03	03	0	T1019		1	$ 24 00	8				

Special needs transportation

School districts must maintain documentation of each service provided, which may take the form of a trip log. Schools must bill only for services that were provided. Special transportation should be billed on a per one-way trip basis. For example, if a client was transported from his or her residence to school to receive Medicaid covered health-related services, and then transported back to his or her residence, it would be billed like this:

24. A						B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
09	02	03	09	02	03	03	0	T2003		1	$ 20 00	2				

Audiology

An audiology assessment would be billed like this (the unit measurement for this code is "per visit"):

24. A						B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
09	02	04	09	02	04	03	0	92557		1	$ 35 00	1				

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's

clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999 -	**888888888** -	**11182003**
Medicaid Provider ID	Client ID Number	Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment coversheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a **7-digit** number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client, verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual. Medicaid eligibility may change monthly.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim when such approval is required. PASSPORT approval is different from prior authorization. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim. Prior authorization is different from PASSPORT authorization. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization does not match current information	• Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim (see *Remittance Advices and Adjustments* in this manual).
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 12-month filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	• Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Procedure is not allowed for provider type	• Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

The Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) do not cover school-based services. For more information on these programs, visit the Provider Information website (see *Key Contacts*). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647

Index

C

D

E

F

G

H

I

K

M

N

O

P

Q

R

S

T

U

V

W